STATE OF RHODE ISLAND
DEPARTMENT OF BUSINESS REGULATION

IN RE:Blue Cross & Blue Shield of Rhode Island Petition for Increase of Rates for Class DIR	:	**DBR No. 04-I-0144**
(Filed September 10, 2004)	:	

DECISION

I.
TRAVEL

This matter came to be heard before the Department of Business Regulation ("Department") as a result of a rate filing ("Filing") received by the Department on September 10, 2004, from Blue Cross & Blue Shield of Rhode Island ("Blue Cross"). The Filing requested rate increases ranging from sixteen and three tenths percent (16.3%) to seventeen and seven tenths percent (17.7%) for Direct Blue Standard and Economy and between seventeen percent (17%) and seventeen and nine tenths percent (17.9%) for HealthMate Coast to Coast Direct, all to be effective January 1, 2005. The Filing also proposed rates for the addition of a new product to be marketed under the name Blue CHiP Direct. The Blue CHiP Direct product is intended to be made available to subscribers beginning January 1, 2005. The rates now in effect for the Direct Pay class[1] were approved with an effective date of July 1, 2003.

In accordance with the provisions of R.I. Gen. Laws § 42-62-13, the Director of the Department designated Elizabeth Kelleher Dwyer, Deputy Chief of Legal Services and G. Rollin Bartlett, Chief Life, Accident and Health Insurance Analyst, as Co-Hearing

[1] The Direct Pay class includes all subscribers in Direct Blue Standard, Direct Blue Economy and HealthMate Coast to Coast. It will also include all subscribers in Blue CHiP Direct should that be approved.

Officers and Charles C. DeWeese as the Department's consulting actuary in this matter. A pre-hearing conference was held on September 30, 2004. Pursuant to R.I. Gen. Laws § 42-62-13, notice of the Filing and of the hearing thereon was published on October 19, 2004 in *The Providence Journal*. Blue Cross mailed notice as required by R.I. Gen. Laws § 42-62-13 to all affected subscribers on October 21, 2004.

On October 22, 2004, the Department sent the following e-mail to all counsel who had entered appearances in connection with the Filing:

> In the course of the Department's Decision on this rate filing, the Department will be considering the effect of R.I. Gen. Laws § 27-19.2-1 *et seq*. on the rating standard to be applied. Any party wishing to present an analysis of this issue for the Department's consideration should do so. If a written submission is to be made, please file on or before November 5, 2004.

On November 1, 2004 the Attorney General filed its "Areas of Disagreement and Alternative Calculations." The Attorney General indicated "[t]he Attorney General's actuary, Timothy M. Harrington, FCA, MAAA,[2] reviewed the rate filing submitted by Blue Cross, the Pre-filed Direct testimony of James Purcell and Michael Recorvits with accompanying exhibits, and responses of Blue Cross to all data requests submitted by the Attorney General to Blue Cross in connection with the Filing. Based upon that review, the Attorney General does not challenge the actuarial calculations contained in the Filing." However, based upon the "affordability" requirements of R.I. Gen. Laws § 27-19.2-3, "the Attorney General request[ed that] Blue Cross reduce its overall filed premium rate by 1%." Blue Cross filed a "Response to Areas of Disagreement and Alternative Calculations" on November 3, 2004. In that document Blue Cross indicated that it "...accepts the alternative calculations made by the Attorney General...in order to

[2] Mr. Harrington's *curriculum vitae* was admitted in this Filing as AG Exhibit 1. At the hearing Mr. Harrington was qualified as an actuarial expert. Transcript of hearing of November 15, 2004, page 94.

expedite the proceedings and save expenses which would otherwise be incurred. Blue Cross does not agree that the newly enacted R.I. Gen. Laws Chapter 19.2 of Title 27 is applicable to mandate the reduction." No further written submission was made regarding the effect of R.I. Gen. Laws § 27-19.2-1 *et seq.* by the parties, although oral argument was offered at the hearing.

The public hearing began on November 5, 2004. The Attorney General was represented by Genevieve M. Martin, Esq., Assistant Attorney General. Blue Cross was represented by Normand G. Benoit, Esq. On November 5, 2004, fifteen (15) members of the public offered public comment and Michael Recorvits, chief actuary for Blue Cross and James Purcell, Chief Executive Officer of Blue Cross, were questioned by the Department's hearing panel. The hearing was continued to November 10, 2004. The same appearances by counsel were made on that date with the addition of Jodi Norse Borque, Esq., Special Assistant Attorney General. On November 10, 2004, three (3) members of the public offered public comment and Mr. Recorvits and Mr. Purcell were questioned by the hearing panel and the Attorney General. At the request of members of the public, an evening hearing was scheduled for November 15, 2004 to allow the opportunity for additional public comment. Twelve (12) members of the public offered public comment at that time and counsel for Blue Cross and the Attorney General offered closing statements.

In its closing statement, Blue Cross concluded "...that based upon the ...uncontroverted facts...in this case and the evidence and the law, that the request must be granted as modified with one percent that we had agreed to." Transcript of hearing of November 15, 2004, page 93. The Attorney General asked that the Department

"...approve the rates with the one percent reduction rather than the entire filed rate request on the basis of a concession by Blue Cross [and that] Blue Cross ...take whatever action is necessary, to reach beyond the scope of this rate filing to find additional ways to help its subscribers be able to continue to afford needed health insurance coverage." Transcript of November 15, 2004, pages 102 to 104. Entered as full exhibits, with the concurrence of all parties, were Blue Cross Exhibits 1 through 21, Attorney General Exhibits 1 through 6, Department Exhibits 1 through 12[3] and Public Comment Exhibits 1 through 132.

II.
JURISDICTION

The Department has jurisdiction in this matter pursuant to R.I. Gen. Laws § 42-62-13. The hearing was conducted in accordance with the provisions of the Administrative Procedures Act, R.I. Gen. Laws §§ 42-35-1 *et seq.*

III.
ISSUES

1. Has Blue Cross satisfied its burden of proving that the requested increase for Direct Blue Economy, Direct Blue Standard and Direct Healthmate Coast to Coast is consistent with the proper conduct of its business and in the interest of the public?
2. Has Blue Cross satisfied its burden of proving that the requested rates for Blue CHiP Direct are consistent with the proper conduct of its business and the interest of the public?

[3] Department Exhibit 6 was produced in discovery along with a request for a preliminary determination of confidentiality Before the hearing, Blue Cross' counsel indicated that the request for confidentiality was withdrawn. Blue Cross agreed that Department Exhibit 6 could be admitted in full in this hearing.

IV.
DISCUSSION

A.
Rating Standard

The standard of review with regard to this rate request is whether the requested rates are "...consistent with the proper conduct of the applicant's business and in the interest of the public..." R.I. Gen. Laws § 42-62-13.[4] The Rhode Island Supreme Court has interpreted this standard on only two (2) occasions. In *Hospital Service Corporation of Rhode Island v. West*, 112 R.I. 164, 308 A.2d 489 (1973)[5] (hereinafter referred to as *West*), the Supreme Court established that it was the burden of the applicant to prove that each of the two (2) factors was met. In *Blue Cross & Blue Shield of Rhode Island v. Caldarone,* 520 A.2d 969 (R.I. 1987) (hereinafter referred to as *Caldarone*), the Supreme Court held that the Director must base his or her Decision upon competent evidence. In neither case did the Supreme Court have the benefit of other statutory enactments to guide its interpretation of what was meant by "proper conduct of the applicant's business."

In 1939 the Rhode Island legislature passed legislation enabling the creation of a non-profit hospital service corporation. In 1945 the Rhode Island legislature passed legislation enabling the creation of a non-profit medical service corporation. These lead to the creation of the entity now known as Blue Cross. Blue Cross was established to fill a gap in hospital and physician financing caused by the failure of many insurance

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[4] This statute applies to all health benefit plans. R.I. Gen. Laws § 27-19-6 and § 27-20-6 are also applicable to Blue Cross. As discussed at length in the Department Decision *In re Blue Cross Class DIR Rate Filing*, DBR 03-I-0021 (hereinafter referred to as *2003 Blue Cross Direct Pay Decision)*, both statutes are applicable except in so far as they are contradictory. The rating standard is identical in both statutes and, therefore, both statutes are applicable to the analysis in this Decision.

[5] Decided prior to the enactment of R.I. Gen. Laws § 42-62-13 under R.I. Gen. Laws § 27-19-6 and § 27-20-6.

companies during the Great Depression. The leaders of the movement that became "Blue Cross" consciously avoided certain aspects of corporate structure and purpose that characterize the "business of insurance." Blue Cross does not have stockholders nor is it a "mutual" company owned and controlled by its policyholders. Blue Cross is a creature of statute and as such is governed strictly by the statutes applicable to it. "There is ... a substantial difference between the purposes and objects sought to be achieved by the statute authorizing the creation of a non-profit hospital and medical service corporation and those authorizing the organization of commercial carriers." *West* at 178, 497.

In *New Hampshire-Vermont Physician Service v. Commissioner*, 132 Vt. 592, 326 A.2d 163 (1974), the Supreme Court of Vermont analyzed an order of the Vermont Insurance Commissioner under a statutory scheme similar to that contained in R.I. Gen. Laws § 27-19-1 *et seq.* and R.I. Gen. Laws § 27-20-1 *et seq.*[6] The Commissioner, in conjunction with a proceeding to approve, disapprove or modify rates, had made a number of orders directing Blue Cross & Blue Shield of Vermont ("Blue Cross Vermont") to offer group coverage to all citizens, cease offering a certain type of contract, eliminate coverage that discriminated against women, increase maximum major medical lifetime benefits and reconstitute its Board of Directors. The Vermont Supreme Court reversed these orders holding that "[t]he Commissioner's regulatory authority should not obtrude itself into the place of management." The Court found that the Commissioner did not have the authority to issue the challenged orders stating:

> We have found nothing either in the statutes or our case law which can reasonably be construed as expanding the passive power of approval and disapproval defined above into the active authority indicated by the

[6] The statutes establishing the non-profit medical and hospital service corporation are similar. However, the Vermont rating standard provides that the rates not be "excessive, unfairly discriminatory or inadequate."

> challenged supplemental orders. A public administrative authority has only such powers as are expressly granted by the Legislature, together with those implied as necessary for the full exercise of those granted. [citations omitted] We do not find the power exercised by the Commissioner to be impliedly necessary for the full exercise of his expressly granted authority. Where the Legislature has intended that such affirmative authority be exercised by an administrative body, it has specifically so stated.

Id. at 166, 596.

Subsequent to that 1974 decision, the Vermont legislature enacted a law applicable to Blue Cross Vermont which provided:

> In connection with a rate decision, the commissioner may also make reasonable supplemental orders to the corporation and may attach reasonable conditions and limitations to such orders as he [or she] finds, on the basis of competent and substantial evidence, necessary to insure that benefits and services are provided at minimum cost under efficient and economical management of the corporation.

8 V.S.A. § 4513(c)

Under 8 V.S.A. § 4513(c), the Vermont Commissioner issued an order to Blue Cross Vermont requiring it to conduct a study of administrative expense reduction, obtain the Commissioner's prior approval for certain capital expenditures and to credit investment income as directed by the Commissioner in future rate filings. Blue Cross Vermont appealed these orders arguing that they "...improperly stepped on management prerogatives." The Court concluded that the Legislature's enactment of 8 V.S.A. § 4513(c) overruled *New Hampshire-Vermont Physician Service v. Commissioner*, *supra* on this issue. The Court stated:

> The fact is that §§ 4513(c) and 4584(c) now specifically authorize, if not require, the commissioner to interpose [his or] her regulatory authority into the 'place of management' and to intervene in order to insure that benefits and services are provided at minimum costs under 'efficient and economical management of the corporation.' Without the authority to

> issue supplemental orders, she would clearly 'not have the means actively to bring this about.'

In re Vermont Health Service Corporation d/b/a Blue Cross and Blue Shield of Vermont Medicomp Rate Increase Application, 115 Vt. 457, 464, 586 A.2d 1145, 1149 (1990).

The Rhode Island legislature has similarly amended the statutes governing Blue Cross. Since the issuance of the *2003 Blue Cross Direct Pay Decision* the statutes governing Blue Cross have changed significantly. Prior to the enactment of R.I. Gen. Laws § 27-19.2-1 *et seq.* in 2004, "proper conduct of the applicant's business" was an undefined term and, essentially, the interpretation of it was left to the discretion of management. The Supreme Court, in *Caldarone*, found that Blue Cross' practice of segregating "classes of business" as "self supporting" was "in the proper conduct of the applicant's business." The court reversed a Department order which, in essence, required other subscribers to subsidize the Medicare Supplement line based upon prior Department orders and management discretion. The Court did not, however, establish that these "lines" were to be "self supporting" for all time. Rather, the Court ruled that the Director did not have any evidence before him to show that management's determination that classes of business should be "self supporting" was erroneous.

In 2004 the Rhode Island legislature established the meaning of "proper conduct of the applicant's business" of a non-profit hospital and medical service corporation with the enactment of R.I. Gen. Laws § 27-19.2-1 *et seq.*[7] The legislature decreed for the first time that Blue Cross' mission is to include providing "...affordable and accessible health insurance to insureds..." R.I. Gen. Laws § 27-19.2-3(1) and "to provide affordable and

[7] R.I. Gen. Laws § 42-19.2-1 *et seq.* is only applicable to non-profit hospital and medical service corporations; it does not apply to insurance companies or health maintenance organizations. The analysis of the rating standard in this Decision is similarly limited to non-profit hospital and medical service corporations.

accessible health insurance to a comprehensive range of consumers, including business owners, employees and unemployed individuals." R.I. Gen. Laws § 27-19.2-3(5). The Board of Directors was specifically charged with "ensuring that the corporation effectively carries out the charitable mission for which it was incorporated..." Under the new law, Blue Cross must also "employ pricing strategies that enhance the affordability of health care coverage..." R.I. Gen. Laws § 27-19.2-10(3). These newly enacted legislative directives show that the "proper conduct of the applicant's business" is no longer left solely to the management's discretion unless that discretion is exercised to provide "affordable" and "accessible" health insurance.[8]

B.
Affordability of Direct Pay Products

The evidence is uncontradicted that Blue Cross is the only corporation currently offering individual health insurance in Rhode Island. The individual market serves those who do not have access to employment based health benefits. R.I. Gen. Laws § 27-19.2-10(a)(2) requires Blue Cross to offer these plans as part of its corporate obligation. As noted by Dr. Peter Oppenheimer in public comment, "...if these plans become too expensive, they cease to be a real option for people...[The Direct Plans must]...be kept affordable so that people who need to buy their own insurance have a true and effective way of doing it." Transcript of hearing of November 5, 2004, pages 24 and 25.

All of the evidence elicited at the hearing and contained in public comment exhibits indicates that Direct Pay subscribers pay the full premium without any portion being paid by an employer or other third party. A Blue Cross witness testified that the

[8] In addition to the plain language of the statute, this interpretation is bolstered by correspondence received by the Department in connection with this rate case from twenty (20) members of the Senate and one (1) member of the House of Representatives (Public Comment Exhibits 86, 126, 127 and 128)

Direct Pay class is made up of persons who are unemployed, work for an employer which does not offer health insurance, are self employed[9] or are retirees not yet eligible for Medicare. Transcript of hearing of November 5, 2004, pages 116 and 117. The Direct Pay class accounts for 2.2% to 2.3% of Blue Cross' overall business. Transcript of hearing of November 5, 2004, page 123. In addition to overall "affordability" Blue Cross is required to consider, pursuant to R.I. Gen. Laws § 27-19.2-3(5), that some of these individuals are unemployed.

Jeffrey Letts, a public comment witness, noted that Direct Pay subscribers are not only paying the full premiums for their own health insurance, they are in essence subsidizing the premium of those who receive insurance through their employer in that the prices paid for goods and services include the cost of employee health benefits paid for by employers. Direct Pay subscribers also pay taxes that support the fringe benefits of government employees. Transcript of hearing of November 10, 2004, pages 13 to 15.

The rates proposed by Blue Cross in the Filing are based upon the experience of the approximately 13,500 persons insured in the Direct Pay class. In the Filing presented by Blue Cross, adverse experience in the class, therefore, raises the rates for Direct Pay coverage; subscribers in other classes insured by Blue Cross do not "subsidize" the Direct Pay class. However, as discussed in more detail below, the "subsidy" for Pool I of Direct Pay, i.e. those who cannot pass a health screening, falls solely on the shoulders of those persons in Pool II who have sufficient health status to be insurable but for one reason or another do not have access to employment based health benefits. Blue Cross has offered

[9] Self-employed individuals are often eligible for insurance under R.I. Gen. Laws § 27-50-1 *et seq* This includes self-employed individuals ("groups of one") which, as of October 1, 2004, must be offered coverage by all insurers writing in the small employer market (currently Blue Cross and Rhode Island licensed affiliates of United Health Group). The public comment elicited at the hearing indicated that in some cases the Direct Pay premium is lower than the small employer premium for "groups of one."

no explanation as to why the Pool II members alone should bear the burden of "subsidizing" the Pool I subscribers.

In the Filing, Blue Cross' only reference to "affordability" is contained on page 26 of the testimony of James Purcell (Blue Cross Exhibit 14). In that testimony Mr. Purcell stated:

> Blue Cross has historically set two goals for itself in Direct Pay: (1) to make coverage "available" to all Rhode Islanders; and (2) to make the coverage as "affordable" as possible – while recognizing that this is an issue which Blue Cross cannot resolve alone. Pool II, the Economy Option, the new HealthMate Direct product and the availability of the proposed Blue CHiP Direct product to all of Class DIR demonstrate our efforts to address this problem. ...Coverage is available to everyone. We believe it is affordable for those who pass the health screening and qualify for Pool II. While it is less affordable in Pool I, those rates have been kept as low as possible and this represents the best blend of availability and affordability consistent with Blue Cross' statutory obligation to maintain its reserve. With this filing we have provided more options to subscribers who may not find Pool I rates affordable or who are not willing to pay the Pool II rates in their entirety though continuing an option benefit programs for Class DIR consisting of the Economy Program, the new HealthMate Direct product and the BlueCHiP Direct product which is proposed to be priced at approximately 35% less than the proposed rates for Direct Blue Standard.

After extensive questioning on the subject by the Department hearing panel, Blue Cross offered additional testimony by Mr. Purcell in which he stated that the issue of "affordability" for this line was addressed by Blue Cross in five (5) ways. Those ways are:

1. Blue Cross "holds off" on filing for rate increases for Direct Pay "for a variety of reasons";[10]

[10] Mr. Purcell indicated that if Blue Cross had filed for a rate increase six (6) months earlier, it would have requested a higher increase based upon the trends it was seeing at that time. It should be noted that trends do not necessarily decrease over time and, therefore, this strategy could also result in higher requested increases.

2. Blue Cross is offering Blue CHiP Direct and Health Mate Coast to Coast Direct as "lower cost" products, although Blue Cross is aware that exchanging lower premiums for higher deductibles may not be affordable in the long run;[11]

3. When applying actuarial judgment, Blue Cross errs on the "low side" for Direct Pay;

4. Blue Cross does not allocate certain expenses to the Direct Pay line;[12] and

5. Blue Cross plans to invest in programs to address utilization, including quality of care and wellness.

Transcript of hearing of November 10, 2004, pages 85 to 88.

As noted above, Blue Cross indicated that some administrative expenses are not allocated to Direct Pay. Blue Cross itself, therefore, does make distinctions between the Direct Pay and group classes. The costs which are not allocated, however, result in only a very slight decrease in the monthly premium charged Direct Pay subscribers. For example, on average, a Direct Pay subscriber pays approximately five cents ($.05) per month for the "Charitable and Corporate dues" line item in the Blue Cross administrative costs (exclusive of Blue Cross and Blue Shield National Association Dues). Transcript of hearing of November 10, 2004, page 60. If Blue Cross allocated this line item across the

[11] Although earlier testimony was somewhat confusing on this point, the Department's actuary confirmed that the premium for these two (2) products is comparable and is approximately 35% less than the premium for the Direct Standard product. Transcript of hearing of November 10, 2004, page 99.

[12] The testimony indicates that certain charitable expenses are not allocated to Direct Pay (Department Exhibit 3, Attorney General Exhibit 6), that none of Mr. Battista's severance package was allocated to Direct Pay (Transcript of hearing of November 5, 2004, page 173) and that certain advertising expenses are not allocated to Direct Pay. (Transcript of hearing of November 10, 2004, page 174.) Blue Cross did not offer specifics on the third item; however, from the evidence presented, the Department has calculated that by not allocating the first two items the average subscriber would save eighty cents ($ 80) per month

board equally to all of its subscribers, Direct Pay customers would, on average, pay thirty five cents ($.35) per month for this line item. While it is laudable that Blue Cross recognizes the unique characteristics of the Direct Pay class in its decision not to allocate this cost across the board, the effect of this action is *de minimus* and does not adequately address the newly enacted statutory mandate of affordability.

Another area in which Direct Pay is treated differently than group business is with regard to Coordination of Benefits pursuant to Insurance Regulation 48 promulgated by the Department. This Regulation, based on a National Association of Insurance Commissioners ("NAIC") Model, requires that individual health products be treated differently because the premium on those products is paid directly by the individual. Although Blue Cross does not agree with the NAIC standard, it does follow Insurance Regulation 48 and treats Direct Pay differently. Transcript of hearing of November 5, 2004, pages 187 and 188.

Blue Cross is currently offering three (3) Direct Pay plans and, with this Filing, is requesting the Department's approval for rates for a fourth plan. The premiums charged for those products vary depending upon the benefits offered in the plan. In general, the plans provide the following benefits:[13]

1. Standard Plan – Basic Hospital and Surgical/Medical, Major Medical, Preferred Rx and Organ Transplant.
2. Economy Plan – Basic Hospital, Surgical/Medical and Organ Transplant.

[13] Each of the plans has certain co-pays and lifetime benefit limits. This is only intended to be a very general discussion of what is included. The Filing and contract forms provide a detailed review.

3. HealthMate Coast to Coast – Basic Hospital and Surgical/Medical, Major Medical, Preferred Rx and Organ Transplant with a $2,000 per member/$4,000 per family up-front deductible.

4. BlueCHiP - Basic Hospital and Surgical/Medical, Major Medical and Organ Transplant (in network only).

Based on the demographic information produced by Blue Cross in response to a request from the Department, approximately 58% of current subscribers have the Standard Plan, 11% the Economy Plan and 31% the HealthMate Plan. (Department Exhibit 7). The plans are offered on an "individual" or "family" basis. The "family" premium is charged whether the family comprises one (1) adult and one (1) child, two (2) adults or a family with two (2) adults and children.[14]

Additionally, Blue Cross has set up two (2) pools in the Direct Pay class; subscribers who pass a "health screening" can enroll in Pool II and all others are placed in Pool I.[15] The following chart shows the current monthly premium for Pool I (subscriber unable to pass health screening) for each product, the monthly premium proposed in the Filing and the monthly premium proposed under the agreement between Blue Cross and the Attorney General.

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[14] Unlike small employer, R.I. Gen. Laws § 27-50-1 *et seq*., there is no statutory directive as to "family composition" for individual insurance. Blue Cross has, therefore, made a management decision to offer Direct Pay on a two (2) tier basis. If Blue Cross were to alter this to a three (3) or four (4) tier model, premium would be reallocated with some persons paying more and others less depending upon the particular family composition.

[15] Blue Cross testified at the hearing that approximately 20% to 25% of the individuals who are screened "pass" and are admitted to Pool II. Transcript of November 10, 2004, page 108. Pool II rates are determined by gender and by six (6) age categories. From the demographic information provided by Blue Cross, the subscribers in each age category are approximately as follows: under 25 – 20%; 25-29-16%; 30-39-24%; 40-49-18%; 50-59-15% and 60-64%-5%. Although the 60-64 year old bracket represents only 5% of the Direct Pay subscriber population, the public comment regarding affordability came disproportionately from this age category.

POOL I PREMIUMS

	Current	Requested in Filing	Blue Cross/Attorney General Agreement
Standard-individual	$ 471.38	$ 550.79	$ 545.28
Standard-family	$ 887.78	$ 1032.49	$ 1022.17
Economy-individual	$ 312.90	$ 368.07	$ 364.39
Economy-family	$ 551.80	$ 648.19	$ 641.71
HealthMate-individual	$ 310.28	$ 364.61	$ 360.96
HealthMate-family	$ 592.60	$ 696.80	$ 689.83
CHiP-individual	n/a	$ 359.59	$ 355.99
CHiP-family	n/a	$ 662.58	$ 655.95

The Pool II rates are set by gender and age and are lower for younger persons. The following chart shows the current monthly premium range for Pool II (subscriber is only eligible if passes health screening) for each product, the monthly premium range as proposed in the Filing and the monthly premium range as proposed under the agreement between Blue Cross and the Attorney General.

POOL II PREMIUMS

	Current	Requested in Filing	Blue Cross/Attorney General Agreement
Standard-individual	$152.04–$471.38	$177.42-$550.79	$175.65-$545.28
Standard-family	$510.50-$887.78	$594.17-$1032.49	$588.23-$1022.17
Economy-individual	$96.72-$309.72	$113.37-$364.31	$112.24-$360.67

Economy-family	$337.99-$551.80	$396.32-$648.19	$392.36-$641.71
HealthMate-individual	$102.89-$310.28	$120.90-$364.61	$119.69-$360.96
HealthMate-family	$338.30-$592.60	$396.30-$696.80	$392.34-$689.83
CHiP-individual	n/a	$111.91-$359.53	$110.79-$355.93
CHiP-family	n/a	$390.99-$662.58	$387.08-$655.95

As the charts show, for each plan within Direct Pay the Pool I rate is equal to the maximum Pool II rate. The only individuals who will pay less than the maximum premium are those who are both under 60 years of age and pass a health screening. From the Filing, the Department has calculated that approximately 55% of subscribers are in Pool I, which means that they would pay the maximum premium.[16]

[16] Blue Cross has also filed rates for persons over 65 in the Direct Pay plans. There are approximately eighty-five (85) persons in the Standard Plan and fifteen (15) in the Economy Plan who are over age 65. In general, Direct Pay coverage is not offered to persons over age 65; however, state and federal law require carriers to guarantee renewability of individual health benefits, even after age 65. The premiums for persons over 65 for the plans offered are:

OVER AGE 65 PREMIUMS

	Current	Requested in Filing	Blue Cross/Attorney General Agreement
Standard-individual	$735.99	$861.31	$852.70
Standard-family	$1375.45	$1602.06	$1586.04
Economy-individual	$478.01	$562.60	$556.97
Economy-family	$840.46	$988.26	$978.38
HealthMate-individual	n/a	$575.89	$570.13
HealthMate-family	n/a	$1087.43	$1076.56

The public comment provides numerous examples of premiums that the Department cannot possibly conclude are "affordable." For example Elaine Gambardella commented that the current premium she pays accounts for 18% of her Adjusted Gross Income. If the rate increase were approved as filed, this would increase to 20% of her Adjusted Gross Income. Transcript of hearing of November 10, 2004, page 16, lines 17 to 23. William Greenwood commented that, as an early retiree, he pays $7,000 per year for a plan which has a $2,000 deductible. After payment of his premium each month he is left with $150 from his pension and social security. Transcript of hearing of November 5, 2004, page 40, lines 2 to 4. Fay Darling indicated that her premium exceeded 25% of her take home pay. (Public Comment Exhibit 5). Martha Pazzullo indicated that she goes without some medications in order to afford the premium. (Public Comment Exhibit 8). Alice Graham indicated that she was paying $312.90 a month on a $12,000 annual salary. (Public Comment Exhibit 35). Barbara Lafaire identified herself as a 64 year old widow paying $1,414.14 quarterly on a $17,000 per year salary. (Public Comment Exhibit 50). Jimmy McClain indicated that 25% of his gross income went to paying his premium (Public Comment Exhibit 56). Steven Costantino indicated that 14% of his gross income went to payment of the premium. (Public Comment Exhibit 62). Sarah Emmons spends one half of her monthly income on premium in addition to $100 in prescription co-pays. (Public Comment Exhibit 88). Margrit Dallaire indicated that her health insurance premium was her single largest monthly expense. (Public Comment Exhibit 91).

As mentioned earlier, the Direct Pay class is one established by Blue Cross. There is no statutory mandate that it be self supporting. Rhode Island does not have a

"high risk pool" and Blue Cross is mandated to offer individual coverage. In satisfaction of this requirement, Blue Cross offers Direct Pay. In fact, Blue Cross often refers to itself as the "insurer of last resort." Transcript of hearing of November 5, 2004, page 90. Blue Cross argues that "...under the present case law, present statutes and the present setup, each group stands or falls on its own in terms of its rating category." Transcript of hearing of November 5, 2004, page 90. The Department does not agree with this conclusion. As a result of the enactment of R.I. Gen. Laws § 27-19.2-1 *et seq.*, the discretion of management to segregate this class and require it to be "self supporting" no longer exists unless Blue Cross' approach result in "affordable" rates.

Blue Cross argued throughout the hearing that the Department should not require a "subsidy" of this class by other Blue Cross subscribers. This argument ignores the fact that all insurance by its nature creates subsidies. The nature of health insurance is to pool the premiums from the entire insured population to subsidize the sick. In segregating Direct Pay in the manner in which it has done, Blue Cross has in essence, caused that subsidy to fall on the extremely small group of people in Pool II. The subscribers who qualify for Pool II are both able to pass a health screening and are under the age of 60. Blue Cross has not provided any evidence as to why the "subsidy" for Pool I should come only from those persons in Direct Pay Pool II. The ratio of claims to premium for 2004 year-to-date is 108% for Pool I, but 66.7% for Pool II. If Pool II stood on its own, it would qualify for a substantial rate decrease.

A "belief" that an alternative method of subsidizing Pool I would adversely affect the solvency of the corporation is not sufficient to satisfy the newly enacted statutory standard. At the hearing Blue Cross argued that an interpretation of "affordable" now

being set forth in this opinion, could lead to the eventual insolvency of the company. Blue Cross testified to this "slippery slope" argument as follows:

> Once you embed inadequacy in rates, it's a terrible thing to turn around. It is – so I think it is the first step toward financial insolvency if you start doing this. I don't want to cry wolf. If we lost $1 million one year, would it put us at risk? Of course not. I can't say that. I'm saying, through, once you start down this path, it's a very, very dangerous path to go because it's hard to pull out of it. So I would strongly urge that that would be the worst way to address affordability, false way to address affordability.
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> Transcript of hearing of November 10, 2004, page 91.

Blue Cross confirmed, however, that denial of the increase requested in this Filing would not in and of itself cause the financial solvency of the company to be impaired. Transcript of hearing of November 10, 2004, page 90. However, it also offered the following testimony with regard to its financial losses during 1998

> . . .one of the things that a nonprofit hospital charitable hospital service corporation has to do is look at not just at the bottom line but also at the overall community. But it can't ignore the status of its reserves. We know what happened in 1998. We were scared to death that we were going to go under the water and our Blue Cross name and mark would be taken away from us and, thereafter, when what happened with Harvard Pilgrim and it happened with Tufts it became even more apparent for the need of reserves. That was then and this is now. We appear to be very healthy, and people have short memories. But there is nothing more important, whether it be a hospital service corporation or anyone else that reserves be adequate to make sure we're always there to pay our claims and operating expense.
>
> Transcript of hearing of November 5, 2004, page 198 and 199.

It might be tempting to infer that those losses may have been related to rates charged to the Direct Pay Class during that year. Such an inference would be contrary to the facts. According to Blue Cross' Quarterly Reserve Reports to the Department for that year, overall corporate reserve (including Direct Pay) declined from quarter to quarter,

beginning at $99, 046,966 (1.52 months of claims and expenses) on December 31, 1997 and ending at $76,592,762 (1.25 months) on December 31, 1998. By contrast, reserve allocated to Direct Pay during the same period increased, beginning at $4,392,118 (2 98 months) on December 31, 1997 and ending at $5, 033,953 (3.30 months) on December 31, 1998. Blue Cross' losses in 1987 were $22,454,294, more than four (4) times the total reserve allocated to Direct Pay. Whatever may have caused the losses of 1998, they appear not to be attributable to Direct Pay.

The Department is an administrative agency that implements the statutes passed by the legislature. The appropriateness of the "affordability" rating standard has been determined by the legislature and is being implemented by this Department.[17] Arguments by Blue Cross regarding the effect of the implementation of this standard would necessarily be addressed to the legislature. However, as long as the statute provides for "affordability" as a rating standard, the Department is required to enforce that standard.

These facts certainly do not support a conclusion that Blue Cross has adequately addressed in connection with this Filing the "affordability" part of its mission for Direct Pay subscribers. While the Department appreciates and supports the efforts Blue Cross has made toward addressing the issue of "affordability," these efforts do not satisfactorily respond to the change in approach mandated by R.I. Gen. Laws § 27-19.2-1 *et seq*. In fact, with the exception of the proposed addition of the Blue CHiP product, Blue Cross

[17] The Department does note that if evidence were produced that the actual rate increase at issue, if denied, would make Blue Cross insolvent or threaten or impair its solvency, that consideration would have to be read together with the direction of R.I. Gen. Laws § 27-19.2-3. Indeed, the threat to financial solvency would have to be seriously considered in conjunction with the issue of "affordability" in order to ensure that the "public interest" is ultimately served. The same is true if Blue Cross' overall corporate reserves were to fall below one month as required by R.I. Gen. Laws § 27-19-6. As noted in *Caldarone*, the Department cannot order a result which violates this statute. As noted in this opinion, reserves are not to be judged on a line by line basis and, therefore, the "deficit" in reserves presented by Blue Cross does not exist.

did not change its approach to this class at all from the last Direct Pay rate filing. In other words, all of the approaches to "affordability" identified by Blue Cross were in place prior to the enactment of R.I. Gen. Laws § 27-19.2-1 *et seq.* Blue Cross has not, therefore, made any change to the design or rating of its "classes" or made any other changes required as a result of this clear legislative directive.

Blue Cross' argument is that R.I. Gen. Laws § 27-19.2-1 *et seq.* calls for no change at all in rating methods. In closing argument, Blue Cross stated that R.I. Gen. Laws § 27-19.2-1 *et seq.* "...doesn't change the long-held applicable rules of what I'll call the *Caldarone* decision and the *Caldarone* doctrine, if you will, that emanated from that decision...I don't think the Legislature somehow implicitly changed the normal standards that are contained in Rhode Island General Law Section 42-62-13." Transcript of hearing of November 15, 2004, page 89. In part, Blue Cross based its argument on the position that "affordability is a very, very significant issue that needs to be addressed, but I don't think it can be addressed within the context of this rate hearing. It needs to be addressed in legislative forums, national and state." Transcript of hearing of November 15, 2004, page 82. "The problem with affordability, and really why it can't be addressed...within the context of this rate hearing is it's a very, very slippery slope; it's a large, societal problem, we can't solve here in Direct Pay. Affordability relates to a person's ability to bear the cost of something." Transcript of hearing of November 15, 2004, page 86.

This argument ignores the fact that the legislature has established "affordability" as a rating standard. The Department concludes that Blue Cross no longer has the managerial discretion to segregate the "Direct Pay" class and require it to be "self

supporting" if that approach does not lead to "affordability." Blue Cross has not satisfied its burden of proof that the rates proposed in the Filing are "affordable" and, are therefore, "consistent with the proper conduct of its business and in the interest of the public."

C.
Administrative Costs and Reserves

In 2004 the legislature empowered the Department to review each administrative cost of a non-profit hospital and medical service corporation and determine its reasonableness. R.I. Gen. Laws § 42-14.5-3(b)[18] specifically provides "...the commissioner shall recognize that it is the intent of the legislature that the maximum disclosure be provided regarding the reasonableness of individual administrative expenditures as well as total administrative costs."

The testimony in this rate hearing was that 9.4% of the rate was attributable to administrative costs. As Department Exhibit 1 shows, individual expenditures that are spread across Blue Cross' entire premium base often have a negligible effect on the rate. However, that does not mean that administrative costs are not to be critically analyzed by the Department under the newly enacted statutes. The legislature has clearly indicated that each individual expense, as well as overall administrative costs, are to be analyzed. As detailed below, Blue Cross, therefore, has the burden of providing detailed information and justification for all administrative expenses in its rate filings if it is to satisfy the requirements of R.I. Gen. Laws § 42-14.5-3.

[18] The chapter was enacted on July 7, 2004. The effective date provision provides that it is effective upon the appointment and confirmation of the Health Insurance Commissioner. The Health Insurance Commissioner has not been appointed or confirmed as of the date of this Decision. However, the Department believes that the standards and directives in the statutes show a clear intent upon the part of the legislature that the Department has the power and duty to inquire into and make orders regarding administrative expenses, until such time as the Department's jurisdiction over these rates is transferred to the Health Insurance Commissioner.

The most common complaint among the public comment related to the severance package given to Blue Cross' former CEO Ronald Battista. Department Exhibit 6 details that the severance agreement cost the corporation $2.1 million dollars. Blue Cross did not allocate any portion of the $2.1 million to the "salaries" or "fringe benefits" charged to Direct Pay subscribers and, therefore, argued at the hearing that Direct Pay subscribers are not affected by the severance package. Whether or not a specific allocation was made, however, does not affect the reality that the corporation has $2.1 million fewer dollars in assets. Had assets not been applied to the severance payment, those assets could have been used to offset costs Under its mission, Blue Cross is to guard its "charitable assets" with the utmost good faith. Since the Department's jurisdiction in this Filing is over the Direct Pay rates, and independent actuaries have confirmed that no portion of the severance agreement was "charged" to Direct Pay, the Department does not have direct jurisdiction over this use of funds. That jurisdiction lies with the Attorney General who, pursuant to R.I. Gen. Laws §§ 27-19-29.1 and 27-20-29.1 has "...the authority to investigate at any time charitable assets for the purpose of determining and ascertaining whether they are being administered in accordance with the law and within its terms and purpose."[19]

Blue Cross argued in this rate Filing that a "reserve deficiency" exists in Direct Pay. Blue Cross asserted that it is currently deficient in reserves allocable to this class for rating purposes by 1.7 million dollars. However, reserves are judged on a class by class basis only for rating purposes under Blue Cross' traditional business practice. Direct Pay

[19] The Department notes that it is the Attorney General's role to investigate and take whatever action he deems appropriate should he determine there has been a misuse of charitable assets. If funds were to be returned to Blue Cross, the Department would have jurisdiction under the newly enacted statutes to assure proper allocation of the returned funds consistent with the statutory mission of Blue Cross.

is not a statutorily segregated class. Rather it is a class segregated for rating purposes by Blue Cross management. Blue Cross as a whole has sufficient reserves and is not in any current danger of insolvency. All statutes on reserves deal with overall corporate reserves not reserves by line of business. Therefore it is the Department's conclusion that there is no "reserve deficiency" which must be remedied in connection with this Filing.

Blue Cross asserts that insurance companies and HMOs do not have reserves. Transcript of hearing of November 5, 2004, page 197. However, it also acknowledges that "reserve" as used by Blue Cross is equivalent to the more common accounting term "surplus" and in testimony, Blue Cross in fact used the terms interchangeably. Transcript of hearing of November 5, 2004, page 124. By whatever name, one major source (and, for a non-profit, virtually the only source) of assets to support the surplus is the money that a company earns in the course of its operations. The process by which a portion of the revenue of a "for-profit" corporation finds its way into stockholder dividends is quite simple. Before looking at this process, however, we must acknowledge that there are two (2) separate processes to consider, rating and operations. In a rate hearing, the Department looks primarily at rating, but the results of past and future operation of the business will govern the practical effect of rating decisions. In rating of insurance, a carrier must take account of expected claims cost and expected administrative expenses, and, no matter whether it is "for-profit" or "non-profit," it must provide a margin for contingencies, including for the generation of sufficient funds to provide a cushion for adverse fluctuations in its business and for investment in capital resources, new products or business ventures. Blue Cross calls this rating element its "reserve factor," but an insurance company might call a similar rating element a "profit margin." Although rating

is intended to anticipate the results of future operations, the actual results of a company's operations determine whether and how much money may be added to surplus and thus become available for general corporate use. These results are usually different from the assumptions made in the course of rating because they are influenced by unanticipated changes, for example, in the number of insured people, in the underwriting characteristics of the people who are covered, in the rate of change in the claim costs and in the cost of operating the business, none of which could have been predicted exactly at the time that the rate was calculated.

When the results of operations are recorded, total expenses for a particular period of time are subtracted from total revenue for the same period of time to determine net income; net income is then added to surplus. It is this accumulation of operating gains that becomes available for general corporate use. "General corporate use" can include such diverse uses as charitable contributions, preparation of studies and reports needed by the community, investment in capital equipment, investment in another enterprise and/or "unassigned funds" for future use. It is from this money that a "for-profit" company may allocate "divisible surplus" for distribution to stockholders. Of course, the for-profit corporation may have a specific need to pay a certain amount of dividend, and it may have provided for that dividend explicitly in its rating process, just as Blue Cross has included certain of its dues and charitable obligations as part of expenses in its rate development. Blue Cross has acknowledged that it does not have to provide for stockholder dividends, whether from surplus or in its rating process. As such, Blue Cross has a competitive advantage compared to "for-profit" insurers in the marketplace. However, it has asserted that its only obligation as a non-profit charity is to price its

service generally without any provision for stockholder dividends. In taking this position, it has failed to consider that Blue Cross may well, for example, be able to develop a program that would provide for a "social dividend" that could be applied to benefit the one (1) class of subscribers that lacks any other entity to cushion the rapid increase in the cost of health care. Just such a "social dividend" is called for in the "affordability" requirements of R.I. Gen. Laws 27-19.2-1 *et seq.*

Blue Cross could provide assistance to the Direct Pay class within the expenses provided for in its rating structure. Blue Cross has indicated its willingness to find an organized charity that would serve the uninsured. Transcript of hearing of November 5, 2004, page 200. It would presumably include contributions to such a charity in its rating scheme as part of its operating expense, in the same manner that it generally provides for other charitable contributions. However, it has failed to consider that it could provide for a charitable element in its rates to recognize the needs of subscribers in that one (1)class that lacks any other entity to cushion the increasing cost of health care. Blue Cross seems to believe that the corporation could continue to operate if it were to allocate more money to contribute to a charity, but that the allocation of the same amount of money to benefit a class of its own subscribers would create a "slippery slope" that would quickly lead to the corporation's demise. While charitable contributions may fit within its non-profit purpose, R.I. Gen. Laws 27-19.2-1 *et seq.* emphasizes that Blue Cross is a fiduciary whose purpose is to provide for affordability and availability of health benefits, even for the unemployed.

V.
ANALYSIS

Under R.I. Gen. Laws § 42-62-13 and R.I. Gen. Laws § 27-19.2-1 *et seq.*, Blue Cross has the burden of proving that the rates proposed are "affordable" and must take into consideration the effect on the "unemployed." This standard means that Blue Cross must prove that it has taken all steps to offer these products, which are mandated to be offered by Blue Cross pursuant to R.I. Gen. Laws § 27-19.2-10, at rates that enhance affordability. Blue Cross has not done so in this Filing.

In order to meet this burden of proof, Blue Cross must, at a minimum, provide the following types of information in filings requesting increases in rates:

1. How Blue Cross has set the rate design of the products to consider "affordability." In this analysis Blue Cross must show consideration of various changes in rate design which would benefit certain categories of subscribers adversely affected by the current design. The considerations should include, but not be limited to:
    a. Modification of the age categories in Pool II. The "age brackets" are in ten (10) year increments causing large increases as persons age and contributing to "rate shock".
    b. Consideration of changing rate design to address the family composition "tiers." Under the current rate design a subscriber may choose only "single" or "family" rates. This means that two (2) adults pay the same as a family with children (assuming that age and plan are consistent).

c. Consideration of a rate design that would not segregate the Direct Pay class to be "self supporting." If it is Blue Cross' position that the rates cannot be modified by a rate design that would share even part of the cost of this class with other classes, it must provide specific evidence to show whether and to what extent such an approach would directly harm its ability to continue to offer group products. Theoretical arguments as to the possible effect of such an approach will not satisfy this burden.[20]

d. Consideration of the use of the "social dividend" discussed above to benefit those for whom health insurance has become most unaffordable.

While the Department does not draw conclusions in this Decision regarding alternative plan designs, Blue Cross' filing should include extensive analysis of the effect of various designs and a complete explanation as to the advantages and disadvantages of each design.

2. How Blue Cross justifies for each and every administrative cost provided for in the rate request. The schedules of categories and "budgets" submitted in this Filing are not sufficient. As indicated in Mr. Purcell's testimony, many categories of administrative expenses have simply been proposed to be increased by 9.6%, an amount representing "inflation" plus increased enrollment in these plans. Transcript of hearing of November

[20] "Theoretical" arguments, without substantive proof, will not suffice. While the theoretical result may occur, the Department needs proof that the predicted result is likely to occur. An example is the argument advanced in the *2003 Blue Cross Direct Pay Decision* that the requested increase would cause decreased enrollment in the Direct Pay Plans. In reality, in the eighteen months since that decision, enrollment has increased from 8,820 contracts to 12,781 contracts. (Blue Cross Exhibit 14, page 10).

10, 2004, page 34. This is not enough for the Department to evaluate the Filing under the newly enacted legislative requirements hereinbefore discussed. Blue Cross must provide detailed information as to what is included in each category and why that expenditure is necessary to provide the product to the subscriber.

3. How Blue Cross has determined the "drivers" of the requested increases in rates and how the additional revenue to be raised is intended to be spent.[21]

In sum, the legislature has stated without equivocation that it should not be "business as usual" for Blue Cross. As the Supreme Court noted in *West*, "...[t]here is [] a substantial difference between the purposes and objects sought to be achieved by the statute authorizing the creation of non-profit hospital and medical service corporations and those authorizing the organization of commercial carriers." *West* at 178, 497. Blue Cross must, by its rate design and premiums, respond to these differences. Blue Cross as a non-profit hospital and medical service corporation does not have stockholders who demand a return on their investment. It, therefore, does not have the same obligation that commercial carriers have when making rates. Therefore, although Blue Cross perceives that it is competing with commercial carriers, under the newly enacted statute its rates must reflect a higher social mission. As confirmed in testimony, Blue Cross uses traditional insurance principles in setting rates. Transcript of hearing of November 10, 2004, page 94 and 95. The legislature has declared that this is not consistent with its

[21] In its Filing Blue Cross indicated that the additional $7.5 million which would be raised as a result of this proposed increase was attributable to "...hospital reimbursement, utilization/mix medical surgical, preferred Rx and other." Transcript of hearing of November 5, 2004, pages 137 to 142. Upon questioning by the Department, the following specifics were indicated: hospital reimbursement – $ 2.8 million, medical surgical – $ 1.5 million, prescriptions- $ 1.3 million, administrative costs - $625,000 and $ 1.3 million "other" identified as including increased hospital utilization and surgical reimbursement. Transcript of hearing of November 10, 2004, pages 92-93.

mission. Blue Cross must alter its business practices to meet the mission clearly set forth by the legislature in R.I. Gen. Laws § 27-19.2-1 *et seq*.

VI.
FINDINGS OF FACT

1. Direct Pay subscribers are unemployed, work for an employer which does not offer health insurance, are self employed or are retirees not yet eligible for Medicare.

2. Direct Pay subscribers pay the full premium themselves without any portion being paid by an employer or other third party. There is no other entity to cushion the effect of health care cost increases on Direct Pay subscribers.

3. Depending upon the plan chosen, the current monthly premium for individuals under 65 in Pool I are $310.28 to $471.38 and $592.60 to $887.78 for families. These rates apply to 55% of the Direct Pay Subscribers.

4. The remaining 45% of subscribers who are in Pool II and under age 60 are eligible for lower rates if they pass a health screening. These rates increase in ten (10) year increments until the age of 60.

5. Depending upon the plan chosen, the current monthly premium for persons over age 65 is $478.01 to $735.99 for individuals and $840.46 to $1375.45 for families.

6. Blue Cross' current rate design requires that Direct Pay Pool II subscribers subsidize Direct Pay Pool I subscribers.

7. Blue Cross' practice of delaying rate increases, not allocating certain expenses to the Direct Pay line, actuarial judgments made "on the low side," offering Blue CHiP Direct and Health Mate Direct and investment in "health and wellness" do

not satisfy the legislative directive that these products should be made "affordable."

8. Blue Cross has not proven that the rates proposed in this Filing are affordable.

9. Blue Cross has not shown consideration of the effect of these rates on the unemployed.

10. Blue Cross has not proven that each and every administrative cost provided for in the rate request is necessary to provide the service to their subscribers. Among other things, the expense allocations are arbitrary, and Blue Cross did not explain why such items as association dues and executive overhead must be allocated at all to Direct Pay.

11. Blue Cross has not proven that the proposed rate design is an appropriate way to consider "affordability" as required under the newly enacted law.

12. There is no evidence that a subsidy of Direct Pay would impair Blue Cross' financial solvency.

13. There was no evidence introduced at the hearing that denial of the increase requested in this Filing would result in Blue Cross not meeting any statutory solvency standard or any solvency standard applied by the Blue Cross Association.

VII.
CONCLUSIONS OF LAW

1. R.I. Gen. Laws § 27-19.2-6 requires that Blue Cross prove that the proposed rates are "affordable."

2. R.I. Gen. Laws § 27-19.2-6 requires that Blue Cross take into consideration the effect of rates on the "unemployed."

3. Blue Cross did not satisfy its burden of proving that the proposed rates are "affordable" or that the effect on the unemployed was given sufficient consideration.

4. R.I. Gen. Laws § 27-19.2-6 defines the "proper conduct of the applicant's business" as providing "affordable" and "accessible" health insurance.

5. R.I. Gen. Laws § 27-19.2-6 requires that Blue Cross offer "individual" insurance.

6. R.I. Gen. Laws § 27-19.2-1 *et seq.* defines the meaning of the rating standard in R.I. Gen. Laws § 42-62-13 as requiring rates which make health insurance "affordable" and "accessible" and which take into account the unemployed. This definition applies only to non-profit hospital and medical service corporations and does not affect the rating standard for insurance companies and health maintenance organizations under R.I. Gen. Laws § 42-62-13.

7. It is consistent with the legislative intent of the newly enacted R.I. Gen. Laws § 42-14.5-3 to require Blue Cross to provide detailed information and justification for all administrative expenses in all rate filings.

8 In order to satisfy its burden of proof, Blue Cross must prove that it has taken all steps to offer individual products at rates that are "affordable."

9. Blue Cross' filing should include extensive analysis of the effect of various rate designs to address "affordability" and a complete explanation as to why any of those designs is determined to be unacceptable.

VIII.
RECOMMENDATIONS

In accordance with the Findings of Fact and Conclusions of Law set forth above, the undersigned find that Blue Cross has not sustained its burden of proof that the

proposed rates submitted by Blue Cross for Classes DIR and the proposed rates for Blue CHiP Direct product are consistent with the proper conduct of its business and in the interest of the public. We recommend that:

1. The proposed agreement between the Attorney General and Blue Cross to approve rate increases at a level of one percent (1%) less than requested be rejected.

2. The rates requested in the Filing for Blue Cross Direct Standard, Blue Cross Direct Economy, Blue Cross Direct HealthMate Coast to Coast and Blue CHiP Direct be denied in their entirety.

3. Blue Cross be directed to file rates for Blue CHiP Direct that are consistent with the Department's disapproval of the increases requested in this Filing for the other Direct Pay plans.

November 23, 2004

Elizabeth Kelleher Dwyer, Co-Hearing Officer

November 23, 2004

G. Rollin Bartlett, Co-Hearing Officer

ORDER AND DECISION

I, Marilyn Shannon McConaghy, Director of the Department of Business Regulation and Insurance Commissioner of the State of Rhode Island, having read the Findings of Fact, Conclusions of Law, and Recommendations of the Co-Hearing Officers in this matter and having satisfied myself as to their validity, do hereby adopt and accept the Findings of Fact, Conclusions of Law and Recommendations of the Co-Hearing Officers.

ENTERED AS AN ADMINSTRATIVE ORDER OF THE DEPARTMENT OF BUSINESS REGULATION THIS 23rd DAY OF NOVEMBER, 2004.

Marilyn Shannon McConaghy
Director and Insurance Commissioner
Department of Business Regulation

NOTICE OF APPELLATE RIGHTS

THIS DECISION CONSTITUTES A FINAL ORDER OF THE DEPARTMENT OF BUSINESS REGULATION PURSUANT TO R.I. GEN. LAWS § 42-35-12. PURSUANT TO R.I. GEN. LAWS § 42-35-15, THIS ORDER MAY BE APPEALED TO THE SUPERIOR COURT SITTING IN AND FOR THE COUNTY OF PROVIDENCE WITHIN THIRTY (30) DAYS OF THE MAILING DATE OF THIS DECISION. SUCH APPEAL, IF TAKEN, MUST BE COMPLETED BY FILING A PETITION FOR REVIEW IN SUPERIOR COURT. THE FILING OF THE COMPLAINT DOES NOT ITSELF STAY ENFORCEMENT OF THIS ORDER. THE AGENCY MAY GRANT, OR THE REVIEWING COURT MAY ORDER, A STAY UPON THE APPROPRIATE TERMS.

CERTIFICATION

I hereby certify on this 23rd day of November 2004 that a copy of the within Decision and Notice of Appellate Rights was hand delivered to:

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